

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/11/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>495002</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/04/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>SOUTH ROANOKE NURSING HOME INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3823 FRANKLIN RD, SW ROANOKE, VA 24014</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  An unannounced Medicare/Medicaid standard survey was conducted 3/3/15 through 3/4/15. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care. The Life Safety Code survey/report will follow.  The census in this 98 certified bed facility was 80 at the time of the survey. The survey sample consisted of 13 current Resident reviews (Residents 1 through 13) and 3 closed record reviews (Residents 14 through 16).	F 000			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain blood pressures and pulses as ordered by the physician for 1 of 16 residents (Resident #5).  The findings included:  For Resident #5, the facility staff failed to follow the physician order to obtain blood pressures and pulses twice a day.  Resident #5 was admitted to the facility 1/10/13	F 309	1) Since the medical record indicates no blood pressures were documented, it is not possible to determine what the readings were at that time. However, to make sure this resident does not experience a repeat we will identify which staff members were involved and provide them inservice on the importance of taking and documenting BP as ordered. They will also receive personal counselling from the Administrator and Director of Nursing.  Also, on 2/22/15 and 2/25/15 we determined that one RN was responsible for documenting 3-11 BP info on the 7-3 flow sheet. Upon discovering her error she drew a line through them but failed to document the results on the 3-11 sheet. This nurse has received personal counselling and will receive additional education before April 3, 2015.		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 309	Continued From page 1  with diagnoses that included but not limited to altered mental status, urinary tract infection, atrial fibrillation, chronic myofascial pain, lumbar spinal stenosis, left ankle fracture, and pressure ulcer right foot.  Resident #5's significant change in assessment minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/4/15 assessed Resident #5 with cognitive summary score of "13" out of "15".  Resident #5's current comprehensive care plan initiated 7/3/14 and revised 1/5/15 included the focus area of hypertension related to congestive heart failure and atrial fibrillation. Interventions read in part "Obtain blood pressure readings as ordered report abnormal to MD promptly."  Physician order dated 1/27/15 read "Check B/P (blood pressure) and pulse bid (twice a day). Record on flow sheet in MAR (medication administration record)."  The surveyor reviewed the clinical record of Resident #5 on 3/3/15. The January 2015 7-3 Daily/Weekly Blood Pressure flow sheet was reviewed. There was no recorded pulse check done on 1/31/15. The January 2015 3-11 Daily/Weekly Blood Pressure flow sheet was reviewed and revealed no blood pressures and pulses were obtained 1/27/15 and 1/28/15. The February 2015 7-3 Daily/Weekly Blood Pressure flow sheets were reviewed. Blood pressure/pulses obtained on 2/22/15 and 2/25/15 had a line drawn through them. The February 2015 3-11 Daily/Weekly Blood Pressure flow sheet had a line drawn through the results of the blood pressure/pulse on 2/13/15.	F 309	2) It is possible all residents that have an order for BP monitoring could be affected if these orders are not followed or if staff fails to document adequately. Therefore, all charts will have to be reviewed to determine if any other resident has been affected.  <i>4/3/15</i> 3) On or before the facility will conduct a detailed inservice for all nursing staff regarding the timely taking and documentation of BP readings. We will also designate a night nurse to review flow sheets every 24 hours to ensure compliance.  4) For the next 3 months and randomly thereafter the Director of Nursing or her designee will monitor compliance by performing a weekly audit of flow sheets. The Director of Nursing will meet weekly with the Administrator to review her findings. All results will be forwarded to the QA committee for review and guidance.  5) All items involving F 309 will be complete by April 3, 2015		

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F 309	Continued From page 2  The January 2015 and February 2015 nurse's notes were reviewed. There was no evidence in the nurse's notes that the blood pressures/pulses had been obtained.  The surveyor addressed the concern with the director of nursing on 3/3/15 at 2:30 p.m. The director of nursing stated the entries with a line through them were done in error by the nurse. She stated the ones that have the lines drawn through them were documented on the wrong shift. She stated she did not know the reason the blood pressures/pulses were not obtained on the other days.  The surveyor informed the administrator, director of nursing and the administrator in training of the above finding on 3/3/15 at 4:10 p.m.  No further information was provided prior to the exit conference on 3/4/15.	F 309			
F 514 SS=B	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	1) Since the medical record does not show adequate documentation, it is not possible to determine what these readings were on the dates listed. However, we will determine which staff failed to document and provide them with additional education as well as a personal counselling session with the Administrator and Director of Nursing regarding the importance of following MD orders and then properly documenting their actions.		

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F 514 Continued From page 3

This REQUIREMENT is not met as evidenced by:

Based on staff interview and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for 3 of 16 residents (Resident #1, Resident #5, and Resident #13).

The findings include:

1. For Resident #1, the facility staff failed to document blood sugar results in the clinical record and failed to document the events of an emergency room visit on 1/13/15.

Resident #1's clinical record was reviewed 3/3/15. Resident #1 was admitted to the facility 2/5/13 with diagnoses that included but not limited to diabetes mellitus, progressive supranuclear palsy, left knee replacement, hypertension, memory loss, osteoarthritis, hypokalemia, neuropathy, and renal insufficiency.

Resident #1's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/26/15 assessed Resident #1 with a cognitive summary score of "14" out of "15".

Current comprehensive care plan initiated 2/5/14 and revised 1/13/15 revealed a focus area for Nutrition and read "Resident has Diabetes Mellitus." Interventions listed were "Accuchecks ac and hs (before meals and at bedtime) for 1 week."

The clinical record revealed a physician order dated 1/13/15 that read "Accuchecks ac and hs (before meals and at bedtime) for 1 week" then a

F 514

F-514 cont.

1) cont.

Also, when contacted about not making a note in the chart about sending the resident to the ER, the nurse involved was adamant that she had done so and that she had contacted the MD and family. Upon further investigation we found she had made a thorough note but when the notes were thinned these notes accidentally got put in her room-mates chart. Unfortunately, we did not discover this until after the surveyors left. Nevertheless, we have enclosed the note for your review.

2) All residents have the potential to be affected if staff fails to properly follow MD orders or to thoroughly document that they have done so. Therefore, on or before April 3, 2015 100% of charts will be reviewed to determine if any other resident is affected.

3) Additional inservice will be conducted for all RNs and LPNs concerning this issue. The Administrator and Director of Nursing will also meet with each staff member on an individual basis.

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F 514	<p>Continued From page 4</p> <p>second physician order dated 1/22/15 read "accucheck before breakfast and supper."</p> <p>The January 2015 medication administration record (MAR) was reviewed. The MAR revealed nurse's initials in all the boxes from 1/14/15 through 1/20/15 except for the 6:30 a.m. accucheck ordered for 1/20/15. The surveyor found no recorded results on the MAR. L.P.N. #1 stated accucheck results are recorded on the flow sheet. The "Blood Sugar Checks" flow sheet for January 2015 was reviewed. The surveyor found no recorded results for 1/16/15 at 4:30 p.m., 1/17/15 at 9:00 p.m., 1/28/15 at 4:30 p.m. and 2/3/15 at 6:30 a.m. L.P.N. #1 was asked if there were any other places where blood sugars were recorded. She stated "No."</p> <p>Also, during the review of Resident #1 's clinical record, the physician order dated 1/13/15 read "Send to ER due to s/s (signs and symptoms) of CVA (stroke) and change in condition diagnosis of supranuclear palsy." Upon review of the nurse's notes of 1/13/15, the surveyor found no documentation of the signs and symptoms that were present upon Resident #1's transfer to the emergency room or any nursing assessment documented. The surveyor interviewed the director of nursing on 3/3/15 at 2:00 p.m. She reviewed the nurse 's notes and stated she would expect a trip to the emergency room to be documented in the nurse 's note.</p> <p>The 1/13/15 hospital emergency department encounter note listed " low blood sugar " as diagnosis.</p> <p>The surveyor informed the administrator, director of nursing, and the administrator in training of the</p>	F 514	<p>3) cont.</p> <p>to make sure each of them understands the importance of this matter.</p> <p>4) For the next 90 days and randomly thereafter, the 11-7 RN will conduct a daily review of the MAR to make sure all medication given over the last 24 hours was properly signed off. This report will be given to the Director of Nursing for review and follow up. The Director of Nursing will provide the Administrator a weekly report of her findings. This information will be forwarded to the QA committee for guidance and rec- ommendations.</p> <p>5) All items involving F 514 will be complete by April 3, 2015</p>		

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F 514	<p>Continued From page 5 above finding on 3/3/15 at 4:10 p.m.</p> <p>No further information was provided prior to the exit conference on 3/4/15.</p> <p>2. The facility staff failed to document when medications were administered on the medication administration record for Resident #5.</p> <p>Resident #5 was admitted to the facility 1/10/13 with diagnoses that included but not limited to altered mental status, urinary tract infection, atrial fibrillation, chronic myofascial pain, lumbar spinal stenosis, left ankle fracture, and pressure ulcer right foot.</p> <p>Resident #5's significant change in assessment minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/4/15 assessed Resident #5 with cognitive summary score of "13" out of "15".</p> <p>The clinical record of Resident #5 was reviewed 3/3/15. A physician order dated 2/16/15 read "Clarification: Septra DS bid (twice a day) for 10 days for cellulitis."</p> <p>A review of the February 2015 medication administration records revealed no evidence the Septra was administered 2/18/15 at 5:00 p.m. as well as the Culterell. Both boxes revealed no nurse's initials that indicated a medication had been administered.</p> <p>The surveyor interviewed registered nurse #1 on 3/3/15 at 3:45 p.m. She reviewed the February 2015 MARs and stated "I gave them."</p> <p>The surveyor informed the administrator, the</p>	F 514			

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F 514	<p>Continued From page 6</p> <p>director of nursing and the administrator in training of the above finding on 3/3/15 at 4:10 p.m.</p> <p>No further information was provided prior to the exit conference on 3/4/15.</p> <p>3. For Resident #13, the facility staff failed to document medications administered on the medication administration record.</p> <p>The clinical record of Resident #13 was reviewed 3/4/15. Resident #13 was admitted to the facility 2/16/15 with diagnoses that included but not limited to laryngeal cancer, hemiparesis affecting left side secondary to cerebrovascular accident, melanoma, hyperlipidemia, hypertension, pre-diabetes, squamous cell cancer, dysphagia, and stridor.</p> <p>Resident #13's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/16/15 assessed the resident with a cognitive summary score of 14.</p> <p>A review of the February 2015 and March 2015 medication administration records (MARs) revealed "holes"-times there was no documentation that the medication had been administered. There was no documentation that Seroquel 25 mg was administered at hs (bedtime) on 2/28/15, 3/2/15 and 3/3/15.</p> <p>The surveyor interviewed the director of nursing on 3/4/15 at 10:30 a.m. concerning the lack of documentation by the nurse of the medication administration. She was asked if she would expect nurses to document when medications are administered. She stated yes.</p>	F 514			

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F 514	Continued From page 7  The surveyor informed the administrator, the director of nursing, and the administrator in training of the above finding on 3/4/15 at 12:50 p.m.  No further information was provided prior to the exit conference on 3/4/15.	F 514			

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